



## Open Research Online

### Citation

Berry, Michael and Barker, Meg John (2015). Sex therapy. In: Richards, Christina and Barker, Meg John eds. Handbook of the Psychology of Sexuality and Gender. Basingstoke: Palgrave MacMillan, pp. 353–373.

### URL

<https://oro.open.ac.uk/43891/>

### License

None Specified

### Policy

This document has been downloaded from Open Research Online, The Open University's repository of research publications. This version is being made available in accordance with Open Research Online policies available from [Open Research Online \(ORO\) Policies](#)

### Versions

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding

Sex Therapy  
**Psychologists Practicing Sex Therapy**

Authors: M. Berry & M. Barker

*In Handbook of the Psychology of Sexuality and Gender*

Edited by C. Richards & M. Barker

## **Introduction**

It is difficult to pinpoint an exact moment when sex therapy began. While the use of psychology and psychotherapy, as they are currently understood, in treating sexual issues is a relatively recent phenomenon, human interest in sexual satisfaction is a timeless issue and ancient civilizations had a wide variety of strategies for dealing with sexual problems. Historical research suggests that the ancient Greeks and Romans, for instance, used a panoply of herbal remedies, magical devices such as amulets and charms, and prayer to gods, as means of dealing with sexual difficulties (McLaren, 2007). During the middle ages, Western Europeans used similar methods (Taberner, 1985) as well as attributing sexual problems to suspected ‘witches’: usually poor, eccentric, or socially marginal women who were thought to have robbed people of their sexual ‘potency’ (Rider, 2006). Clearly, while our interest in sexual health and functioning can be traced back through the millennia, accepted treatment methods have changed dramatically since the days of witch-burning and Spanish fly<sup>1</sup>. Nevertheless, our understanding of sexual therapies can still benefit greatly from being considered within a sociohistorical context, given that accepted treatments continue to reflect and perpetuate prevailing cultural understandings of sex, gender and selfhood.

In this chapter, we take account of key sociocultural factors as we outline some of the core principles of sex therapy and illustrate the key psychological bases of current concepts and debates. First, we describe the recent history of sex therapy, tracing the trajectory of the discipline from Freud to the present day, and identifying some of the principal psychological theories and psychotherapeutic models used in the field. We then present a number of the current debates in sex therapy, describing the critical views of psychologists and therapists who have challenged traditional notions of sexual behaviour, gender roles, and diagnostic categories. Finally, we identify some of the implications that sex therapy research and practice—especially critical approaches to these—have for applied psychology and psychotherapy, and indicate future directions for clinical practice and for research.

---

<sup>1</sup> A type of poisonous beetle that was used as an aphrodisiac.

## Sex Therapy

### History of psychological (and related) work

Sex therapy has developed against the backdrop of two important elements: a scientific model of sexual behaviour and sexual functioning, and a psychological understanding of human sexuality that links sex to cognitive and emotive processes (thoughts and feelings). The relatively recent development of these fields means that the specific and targeted use of psychotherapy in treating sexual problems is itself a relatively recent phenomenon (Berry, 2013). Of course we may perceive an important psychological dimension—in the form of a placebo effect, or implicit psychological influence—in the treatment practices of ancient and medieval societies mentioned above. However, the theoretically grounded and scientifically-based practice of sex therapy today is the product of recent developments in psychology, medicine, and related disciplines. Sex therapy, as it is currently understood, is based principally on a psychological conceptualization of human sexuality (Bancroft, 2006). Consequently, the emergence of sex therapy as a distinctive discipline has important precursors in the history of psychological thinking about sex.

The first of these precursors is arguably found at the beginning of the twentieth century when a number of influential psychological researchers and theorists turned their attention towards human sexuality and began considering the ways in which sexual identities and behaviours—and problems with these—emerged, thus laying the groundwork for the development of contemporary sex therapy. Perhaps key among these is Sigmund Freud who is credited with developing many important theories on the role that sex plays in the psychology of the individual (Hartmann, 2009). For instance, well-known concepts such as neurosis, repression, the Oedipus complex, and the presence of unconscious factors in our sexual lives, continue to influence the ways in which people think about the psychology of sexuality. Indeed, throughout the first half of the twentieth century, sexual issues were most often treated by psychiatrists, who tended to work within a psychoanalytic or psychodynamic model of practice, heavily influenced by the work of Freud (Goodwach, 2005). It is important to note, however, that Freud's work has been subject to considerable criticism amongst psychologists and sexologists in recent decades. It has been argued that many of Freud's theories are largely *non-falsifiable*—meaning that they cannot be tested by objective scientific measures (McCarthy, 1981).

Nonetheless, three theories, which can be traced to Freud, are particularly important in contemporary sex therapy. First, it is believed that sexuality is an important part of a person's psychology throughout their life course, and even from infancy (Fonagy, 2008; Freud, 1961). Secondly, it is understood that seemingly non-sexual factors may have underlying sexual dimensions (Hawton, 1985; Wincze & Carey, 2001). Thirdly, the inverse view is also shared by many sex therapists and sexologists, who hold that sexual problems in an individual's life are often highly influenced by non-sexual factors, especially relationship issues and physical illness (Denman, 2004). In short, sex therapists tend to see sex in a contextual way—as inherently interwoven with the rest of an individual's life.

## Sex Therapy

During the latter half of the twentieth century, a significant shift towards more cognitive and behavioural models of sexual behaviour, and forms of intervention, occurred. Alfred Kinsey, an American sexologist, particularly influenced the understanding of human sexuality through a series of behaviourally-focused studies (Gathorne-Hardy, 1998). Between 1938 and 1956, Kinsey and his associates conducted eighteen thousand personal interviews which aimed to uncover the sexual behaviours of average American citizens. The research focused on the quantitative measurement of sexual behaviour, and the two key works, *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, & Martin, 1953), presented a highly statistical picture of Americans' sexual activities. Alongside their research interviews, Kinsey and his colleagues conducted a series of controversial studies that involved direct observation of research participants engaged in sexual acts (something it would now be very difficult to get ethical approval for). The focus in these was on a sequence of sexual behaviour, from arousal through orgasm, and indeed, Kinsey's research was highly focused on the role of the orgasm, as a measure of normal or healthy sexual behaviour (Gathorne-Hardy, 1998). Many later sex therapists and psychologists have adopted a similar standard, using orgasm—or its absence—as a primary criterion of sexual well-being. However, we will see later in the chapter that this model has been challenged.

After Kinsey's work in the 1940s and 1950s came two of the most important pioneers in the field of sex therapy - William Masters and Virginia Johnson, whose work contributed to a psychological understanding of sexual behaviour and a psychotherapeutic model for the treatment of sexual problems (Masters & Johnson, 1966; Masters & Johnson, 1970). Like Kinsey, in Masters and Johnson's model, human sexual behaviour was seen as following a predictable and essentially universal course, based on the attainment of orgasm. Masters and Johnson also based their sexual response cycle model on observational laboratory data, and defined four distinct phases: (1) the excitement phase; (2) the plateau (stimulation) phase; (3) orgasm, and; (4) resolution (a return to the pre-excited state). Within this system, sexual dysfunction was seen as a non-response, or inappropriate response during any stage of this cycle (for instance premature ejaculation, or pain resulting from sexual stimulation). In this respect, Masters and Johnson's work has been highly influential in terms of both the ways in which sexual problems have been defined and the accepted techniques of sex therapy practice.

Masters and Johnson's research was largely responsible for the important historical shift in the field of psychological treatment for sexual problems from psychoanalytic and psychodynamic models towards cognitive-behavioural theories and treatment systems. While Masters and Johnson acknowledged psychodynamic aspects of sexual dysfunction, they argued that the formerly-dominant psychodynamic-psychiatric treatment methods were too lengthy and costly, and of questionable clinical efficacy. By contrast, cognitive-behavioural therapy (CBT), they suggested, could generally be completed in a few sessions, with

## Sex Therapy

much of the therapeutic work being done by the patient as homework. Furthermore, their CBT paradigm had exceptionally high (self-reported) rates of efficacy. Overall, their influential work contributed to a shift towards a distinctive sex therapy model, largely founded on cognitive-behavioural models of intervention. Many view the treatment system developed by Masters and Johnson as the first expression of sex therapy as a distinct field of treatment.

### Key theory and current research

More recent researchers have argued that the absence of a psychological component is a significant weakness of the Excitation-Plateau-Orgasm-Response model (Basson, 2001; Kaplan, 1979; Tiefer, 1991). To compensate for this omission, Kaplan proposed a revised model of sexual response that included a stage of sexual desire (Kaplan, 1974, 1979; Levine, Hasan, & Boraz, 2009). Kaplan positioned the desire phase prior to the excitement phase, as a psychological state that primes the individual for physiological excitement and arousal (Atwood & Klucinec, 2007; Kaplan, 1979). It was also argued that the plateau phase was redundant, and could readily be conceived as part of the excitation phase (Robinson, 1976). This conceptual evolution resulted in a more recent model of human sexual response: the Desire-Excitement-Orgasm-Resolution (DEOR) cycle, which has been used in mainstream psychodiagnostic systems to conceptualize sexual dysfunctions. These include the *Diagnostic and Statistical Manuals of the American Psychiatric Association (DSM)*, and the *International Classification of Diseases of the World Health Organization (ICD)* (Shrestha & Segraves, 2009). In this chapter we focus on the DSM given that this is the more recently updated of the two, and that the ICD generally follows the DSM in its categorisations.

### Diagnosis

In May 2013, a new edition, *The DSM, 5<sup>th</sup> Edition (DSM-5)* (APA, 2013) was published to replace the previous *DSM, 4<sup>th</sup> Edition, Text Revision (DSM-IV-TR)* (APA, 2000). The categories of sexual dysfunctions in the *DSM-5* relate to any disruption of Kaplan's (1974) revision of Masters & Johnson's (1966) 'sexual response cycle'. Whilst the *DSM-5* now makes it clear that sexual response is not always a linear process, and that distinction between the stages of the cycle may be artificial, key categories do relate to desire, arousal and orgasm. They are as follows:

- 302.71 Male hypoactive sexual desire disorder
- 302.72 Female sexual interest/arousal disorder
- 302.72 Erectile disorder

## Sex Therapy

- 302.74 Delayed ejaculation
- 302.75 Premature (early) ejaculation
- 302.73 Female orgasmic disorder
- 302.76 Genito-pelvic pain/penetration disorder
- 302.79/70 Other specified/unspecified

As can be seen, there are categories for: lack of desire or sexual interest; for 'erectile disorder' or female lack of arousal; and for 'female orgasmic disorder' or 'delayed ejaculation' (still commonly known in sex therapy as 'erectile dysfunction'). In addition to this there are categories of 'premature (early) ejaculation' and of 'penetration disorder'. These latter suggests that not only are desire, arousal and orgasm necessary for functional sex to have occurred, but also that penis-in-vagina (PIV) intercourse is an essential feature, given that it is considered a disorder for a vagina not to be able to be penetrated and for ejaculation to happen prior to penetration (Barker, 2011).

A number of diagnostic criteria are, however, common across the sexual dysfunction diagnoses in *DSM-5*. These include:

Criterion B—persistence of symptoms for at least. 6 months,

Criterion C—symptoms cause clinically significant distress, and

Criterion D—the symptoms are not better explained by another disorder, or by relationship or other stress, and are not due to the effects of a substance/medication.

Thus a person would not be diagnosed with a sexual dysfunction unless they were distressed by it and it had persisted for 6 months. Additionally, a number of diagnostic categories specify that symptoms must be experienced on all or almost all (75%-100%) of occasions of sexual activity.

The diagnosing practitioner is also encouraged by the *DSM-5* to consider whether the sexual problem is: lifelong (present throughout the individual's entire sexual history), or acquired (emergent at a specific point in the individual's sexual history), generalized (present in all sexual encounters/activities), or specific (present only in certain activities, or with certain partners), and whether the condition is likely psychogenic (due to psychological factors alone), or combined (due to both psychological and physiological factors).

During the development phase of *DSM-5*, a substantial number of researchers argued for the importance of socio-cultural and relational factors, alongside psychological variables, in the assessment and diagnosis, and treatment, of sexual problems. Consequently, *DSM-5* stresses that relevant social factors must be taken into account in assessment and diagnosis, including:

## Sex Therapy

1) partner factors (e.g. partner's sexual problems; partner's sexual health status); 2) relationship factors (e.g. poor communication; discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g. poor body image; history of sexual emotional abuse), psychiatric comorbidity (e.g. depression, anxiety), or stressors (e.g., job loss, bereavement); 4) cultural or religious factors (e.g., inhibitions related to prohibitions against sexual activity or pleasure; attitudes towards sexuality) (APA, 2013, p. 423).

Though *DSM-5* has retained a categorical model of diagnosis, the development of the manual was marked by debates about the use of categorical versus dimensional diagnostic paradigms (Balon, 2008; Balon, Segraves, & Clayton, 2007; Mitchell & Graham, 2008). Within a *categorical model* of diagnosis, sexual dysfunctions are seen to differ from normal/healthy sexual functioning in kind, rather than in degree. By contrast, within the *dimensional model* of diagnosis, sexual dysfunctions are seen to differ from normal/healthy sexual functioning in degree, rather than in kind (Krueger & Piasecki, 2002). As Widiger and Samuel (2005) suggest, the categorical model sees diagnostic categories as reflecting "discrete clinical conditions", whereas the dimensional model takes diagnostic categories as reflecting "arbitrary distinctions along dimensions of functioning" (2005, p.494). Overall, the *DSM-5* sexual dysfunction diagnoses reflect a shift towards a more quantitative set of diagnostic criteria.

### *Treatment*

Alongside these diagnostic categories, a sizeable number of standard treatment practices are cognitive and behavioural, and find roots in the model introduced by Masters and Johnson, and developed by Kaplan. Key writer and researcher in this area, John Bancroft, suggests that this model was based less on a core theoretical foundation, and more on clinical application; "it became widely used," he states, "because it proved effective" (2006, p.372). As such, it may be argued that mainstream sex therapy is largely *technique-driven*, rather than *theory-driven*. Table 1 outlines a number of the main cognitive-behavioural interventions that have traditionally been used in sex therapy.

Insert Table 1 Here

Many contemporary psychologists and psychotherapists in this area take an integrative approach to clinical practice (Meana & Jones, 2011; Perelman, 2005; Toates, 2009; Weeks, 2005), guided by the

## Sex Therapy

*biopsychosocial model* of health care practice. The *biopsychosocial model*, which the World Health Organization holds as a process of care standard in the sexual health field, prescribes attention to the biological, psychological *and* social aspects of the client's sexual problems (Montorsi et al., 2010; World Health Organization, 1993). Figure 1 provides a graphical overview of the biopsychosocial model of human sexuality.

Insert Figure 1 Here

However, the wide-scale implementation of this model in clinical sex therapy has proven challenging—with a number of researchers suggesting that the biopsychosocial paradigm has often been a matter of 'lip-service' rather than actual practice (Barker, 2014), as the next section will illustrate.

### Current debates

While standardized diagnostic categories provide a general view of how applied psychologists conceive of their clients' and patients' sexual problems, the conventional diagnostic categories outlined in standard psychiatric manuals are contested by many people working in this area (Kleinplatz, 2012b). Leiblum (2007), for example, summarises some key challenges:

What constitutes a sexual disorder?...How important is the degree or existence of personal distress as a diagnostic criterion?...Who determines treatment success: the clinician or the patient? How do we evaluate treatment success? Greater sexual frequency? Increased feelings of satisfaction? (p. 4)

One set of issues with diagnosis are highlighted by Levine's (2006) hypothetical example of a male client who experiences some incidence of quick ejaculation. This experience fosters a sense of anxiety about the sexual encounter and worry about future performance. In turn, such anxious ideation prevents the client from getting an erection on a number of future occasions. Frustrated by these problems, the patient develops an avoidant, disinterested attitude towards sex. While such a client might fit the criteria for three diagnoses—early ejaculation, erectile dysfunction, and hypoactive sexual desire disorder—the value of using multiple diagnoses to describe a clearly interrelated set of psychological and behavioural factors is questionable. Consequently, as Levine et al. (2009) argue, “when desire, arousal, and orgasmic problems coexist in the same patient, the decision about the most basic dysfunction is arbitrary” (Levine et al., 2009, p.164). Some argue

## Sex Therapy

that, rather than distinct diagnoses, sexual disorders are in fact symptomatologies resulting from other underlying psychological factors. This argument is in part supported by substantial research indicating a strong correlation between sexual problems, depression and anxiety, relationship factors, and life stress (Barlow, 1986; McCabe et al., 2010; Stevenson & Elliott, 2009).

Another set of issues cohere around the underlying assumption, within several diagnostic categories and in much sex therapy as a whole, that a normal or healthy person will possess a strong psychological motivation for sex—i.e. a relatively high baseline level of sexual desire (Risen, 2010). Based on this assumption, in the *DSM-5*, low or absent desire for sex is the basis for the categories of ‘desire disorder’. Additionally, the category of ‘sex addiction’—which is commonly used by clinical practitioners, but does not appear in *DSM-5*—suggests that healthy sexuality involves a Goldilocks “just right” amount of sexual desire. However, a growing number of researchers have examined asexuality, finding that this does not constitute any kind of sexual dysfunction (see Carrigan, this volume). Thanks to such research, distinctions between asexuality and ‘disordered’ low/absent sexual desire are now reflected in the *DSM-5*, although the pathologisation of asexuality in the past, and its continued marginalization in wider society, may well contribute to distress experienced by asexual people (Richards & Barker, 2013). Critical psychologists have similarly questioned the construct of sex addiction, and the way in which this may serve to pathologise certain groups such as gay men or kink practitioners (e.g. Irvine, 2005).

Consequently, normative models of gender and sexual behaviour, pervasive in much of the sex therapy literature, are important areas of contemporary debate and critical analysis. Critical sexologists and psychologists highlight the fact that homosexuality was classified as a mental illness in the *DSM* until 1973, and in the *ICD* until 1992 (see Riggs, this volume). The relatively recent declassification of homosexuality, and the controversy surrounding this, indicates the important influence that political discourses and social norms exert on the way sexual health problems are defined. Today, gender dysphoria, the ‘paraphilic disorders’ and the sexual dysfunction diagnoses outlined above, are continuing frontiers of this ongoing debate (see also Lenihan, Dundas & Kainth, this volume; Murjan; Turley & Butt, this volume; Barker & Iantaffi, forthcoming 2015).

For this reason critical psychologists and sex therapists have proposed that categorical diagnoses of sexual dysfunction and sexual disorder serve to unduly pathologise clients and patients, and create a sense of pressure and stigma around sexuality and sexual problems (Kleinplatz, 2012a). A number of researchers point to the creation of categories of sexual dysfunction/illness as part of a biomedical model that defines categories of health/pathology with largely arbitrary cut-off points (McCarthy & McDonald, 2009; Tiefer, 2010a, 2010b). It is increasingly argued that sex therapists may benefit from an *idiographic* approach to sexual dysfunction, which tends to interpret the client according to their unique, specific and subjective experience. This is opposed to the *nomothetic* approach, which attempts to explain the client’s experience according to a set of

## Sex Therapy

universal and generalizable traits. Any sexual experience (including desire, arousal, erections, orgasms, or their lack) has very different meanings for each person, related to the relationships and wider culture in which they are embedded (Barker, 2012). Therefore instead of “treatment” of problems with specific medical or behavioural interventions, the therapeutic task becomes one of understanding clients' experiences and what they mean for them, perhaps through the medium of formulation.

Critical psychologists and practitioners point to a fundamental tension between traditional notions of sexual normality—which have informed the development of classic diagnostic, assessment, and treatment models—and newer models that emphasize diversity, a range of experience, and the importance of the client’s *subjective* experience (Kleinplatz, 2012a). Here, there is an important tension between traditional cognitive-behavioural techniques and more recent critical methodologies, which acknowledge a high level of diversity in sexuality and its problems. In our own work, we strongly emphasize the importance of understanding the client on their own terms, within the framework of their lived experience (Berry & Barker, 2013). This requires a sensitive and nuanced understanding of key elements of the client’s identity, including race, sexuality, gender, socio-economic position, and other elements of their lived experience in the social world. Whereas traditional sex therapy has paid limited attention to such factors, recent work has begun to foreground them (Levine, Risen, & Althof, 2010). Such a framework may be grounded in an affirmation of the sexual rights of individuals within an expanded notion of sexual well-being as in the World Health Organization’s definition of sexual health, which states:

Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well-being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld (PAHO/WHO, 2000, p.6, quoted in Giami, p.18).

Additionally, the traditional model of sex therapy largely rests on the assumption that healthy sexuality will follow a particular behavioural course, defined by the sexual response cycle described earlier. Increasingly critics have argued that this model is predicated on a heterosexual model of penetrative, penile-vaginal penetrative sex, which takes orgasms (especially men’s orgasms) as the goal of the behaviour, in which the man takes an active role and the woman a passive one (Nichols & Shernoff, 2007; Kleinplatz, 2012a, 2012b). Related to this is the fact that the conventional model of sexual behaviour used in the sex therapy field tends

## Sex Therapy

to be dyadic; that is, it is generally assumed that sexual relationships will follow a one-to-one monogamous relationship pattern. Solo sex, and sex between more than two people, are rarely considered in sex research (Barker & Langdrige, 2010). Narrowly limited categories of health and normality serve to create exclusionary criteria of sexual health and illness, which at best fails to recognize - and at worst pathologises - sexual diversity.

In addition to this, a model of sexual behaviour based on the centrality of the orgasm, whether within a heterosexual dyad or not, also contributes to a *goal-focused* paradigm of sexuality - which has been argued to contribute to, rather than ameliorating, sexual distress (Barker & Iantaffi, forthcoming 2015). More critical sex therapists advocate the value of a *pleasure-focused* or *process-focused* models in which the experience of enjoyable sex—without the demand of an orgasm, or particular types of highly specified behaviours—is prioritized (Leiblum & Wiegel, 2002; Metz & McCarthy, 2007).

Taken together, research challenging the idea of quantitative thresholds and predetermined behavioural paths for healthy sexual desire and behaviour suggest that it may be impossible to define sexual health according to strict quantitative standards. Accordingly, critical evaluation of the subjective aspects of an individual's sexuality is necessary in practitioners' efforts to understand and treat sexual problems.

### *Important Points for Students:*

For students, critical engagement with psychological research is particularly important when considering sexual issues. Human sexual behaviour is extraordinarily diverse and implicates our political, moral, and personal views of the world. Consequently the study or treatment of sexual problems often (and likely always) involves the student or researcher's system of morality and ethics. It is particularly important to maintain a critical orientation to the complex social values and discourses that surround sexuality and, by implication, sex therapy practices. This type of critical engagement may reduce the risk of biased, aspecific or unduly narrow definitions of sexual health and wellbeing. Students may find it useful to access the resources on [www.sexualitygender.wordpress.com](http://www.sexualitygender.wordpress.com) to help consider their existing ideas about sex.

### **Implications for applied psychology**

In recent years, the critical psychological approach of *social constructionism* has become a key element in critical sex therapy research and practice (see Seymour-Smith, this volume). In addition to subjective lived experience highlighted above, emphasis is placed on the wider social world in which client's experience occur. This requires a *contextual* approach to practice, in which the sex therapist works with the client to interpret the

## Sex Therapy

sexual scripts that inform their sexual life and sexual problems, and analyze the social norms - or discourses - that have influenced such scripts. Here, apparently 'objective' measures of sexual performance—as are often represented in conventional diagnostic systems or sex advice media (Barker, Gill & Harvey, forthcoming 2015)—are de-emphasized. Instead, the subjective meaning of the client's sexual experiences, within the context of the world in which they live out this sexuality, is the focus of the therapy process (Aanstoos, 2012; Kleinplatz, 2012b).

Such work acknowledges that both the client and the psychologist or therapist bring preconceptions, social scripts, values and norms into the consulting room. At times it can be challenging to identify and manage one's own assumptions about normality, and strategies are needed to help psychologists work with clients whose range of experience may be unfamiliar, or even uncomfortable (see Richards & Barker, 2013). Consequently, in our work we have recommended reflexive critical approaches to categories of sexual health and wellbeing, gender, and sexual behaviour (Barker & Langdridge, 2010; Berry & Barker, 2013).

As part of the social constructionist approach an increasing number of sex therapists work to deconstruct the dominant notions of sexuality and gender that infuse clients' sexual experiences (Barker, 2005; Kleinplatz, 2012b; Schilt, 2009; Tiefer, 2006). This often includes analysis of *social discourses* about gender—for instance, the notion that women should look a certain way, or that men should be able to live up to certain standards of sexual performance. Conventional discourses about sexual behaviour and gender roles are seen as potentially constraining: limiting the ways in which clients feel they can experience or enact their sexuality and exaggerating or even artificially instilling negative and self-defeating views. A social constructionist orientation to sex therapy involves questioning and analyzing dominant social notions of 'real men' and 'real women'. For example, popular understandings of male sexuality, perpetuated by male sexual disorders, entrench a 'performance-based' model that obscures or disregards the important role of intimacy and pleasure in sex for many clients (Grace, Potts, Gavey, & Vares, 2006). Binary conceptions of sexuality and gender may contribute to particular, narrowly restricted, forms of *sexual behaviour scripts*—the particular types of behaviours that are considered acceptable (see Harvey, Bowes-Catton; and Barker & Richards, this volume). Drawing on constructionist, feminist and queer perspectives may help the practitioner to engage the client in understanding their sexual scripts and the meanings they associate with sexuality—including their standards of sexual function and dysfunction, normality and abnormality.

One example of social constructionist and feminist informed sex therapy can be found in Barker (2011b) where the author describes their work with a young women who had been diagnosed with 'vaginismus'. Rather than focusing on the sexual problem, the therapist explores the wider worldview of the client – within the context of prevailing discourses - and how sex fits into this. Through shared understandings of the popular 'Bridget Jones' view that it is vital for women to find a romantic relationship, the client and

## Sex Therapy

therapist are able to see the sense in the client's continued engagement in painful sex, as well as exploring the taken-for-granted assumption that failing to do so would result in their male partner breaking up with them. This situation is situated within a wider context of the client attempting to embody a conventional femininity which involves pleasing everybody else and being a good daughter, good friend and good girlfriend. Frustration at the restrictions this places around her enables the client to tune in more to her own desires and goals, and to consider whether this relationship is good for her, rather than focusing only on the desires of her partner.

Obviously a light touch needs to be employed when engaging clients in such work, inviting them to identify – and perhaps deconstruct – prevailing discourses in the world around them – rather than directing them, for example. However, certainly in this case, elements of the 'vaginismus' experience were illuminated which would not have become apparent employing conventional sex therapy approaches towards less painful penetrative sex.

One of the most important implications of new and emerging critical sex therapy approaches is the challenge they represent to conventional assumptions about sexual health and behaviour. Traditionally, sex therapy has reflected and perpetuated wider social discourses, defining normality and abnormality, healthy and unhealthy, in ways that align with the popular view (see Drescher, 2010). Increasingly, however, some psychologists and practitioners in this field have argued for a more critical and open stance towards sexual diversity in both sex therapy and popular understandings and representations (see Barker, Gill & Harvey, forthcoming 2015).

### *Important Points for Applied Professionals:*

Research indicates that general medical and psychological practitioners often neglect to inquire about clients' and patients' sexual problems (Temple-Smith, Hammond, Pyett, & Presswell, 1996). Such reticence is due to cultural sensitivity about sexual issues, personal discomfort with discussing clients' sexualities, and lack of specialized training in sexual areas (Athanadiasis et al., 2006; Tsimitsiou et al., 2006). Many sex therapists stress the value of including questions about sexuality in standardized assessment practices, and especially for those clients presenting with relationship issues (Giraldi, Rellini, Pfaus, & Laan, 2013; McCabe et al., 2010; McCarthy & D. McDonald, 2009). One of the important contributions that sex therapy and related research may have for applied psychology is in its emphasis on sexual issues as a core aspect of clients' lives. Many advocate the need for specialized training in sexuality and sex therapy for therapists, psychologists and counsellors who wish to work in this area specifically, both to increase biopsychosocial knowledge and to reflect on one's own assumptions around sex and sexuality.

## Sex Therapy

A number of professional organizations support the work of sex therapists and researchers. These include the *College of Sexual and Relationship Therapists (COSRT)* in the United Kingdom, and the *Society for the Scientific Study of Sexuality (SSSS)* in North America. Such organizations serve as professional networking bodies, hosting conferences and training events for sex therapists and their research-oriented colleagues, and publishing research journals, including the journal *Sex and Relationship Therapy*, and the *Journal of Sex Research*, respectively.

### Future directions

In her updated collection of new perspectives in sex therapy, Kleinplatz (2012b) puts forward a list of future goals for sex therapy which we have summarized below. These are grounded in the kind of idiographic and constructionist approach which we have argued for throughout this chapter. Many of these could also be usefully adapted for academic research in this area.

1. Focus on the ability to be present rather than trying to enable a certain kind of sexual performance (erections, penetration, orgasm, etc.) through understanding clients' subjective meanings and experiences.
2. Appreciate the uniqueness of each client and the huge variety of possible sexual practices and experiences that may work for them, rather than promoting a one-size-fits-all goal for therapy. Here Kleinplatz provocatively (and usefully, we think) suggests that sex therapists could learn a lot from professional dominatrices who make it their business to learn exactly what gets their clients off.
3. Promote social change through sex education and activism rather than continuing to reinforce a problematic normative sexual script (e.g. measuring men's worth by their last erection, buying into cultural ideas about ageing bodies and the value of maintaining youth, or assuming that women must be penetrated in order to maintain their relationships).
4. Be guided by clients rather than by categories of functioning and dysfunctioning. For example, rather than trying to get penises to penetrate or vaginas to be penetrated, attend to the whole person and to the sensible reasons why this might not be a safe or desirable thing to do (for example because they want to be valued for more than their sexual performance, because past relationships have left them fearful of letting people in, or because sex has become all about pleasing others with no attention to what turns them on).

## Sex Therapy

5. Get to the core of clients' pain and joy, hopes and despair, and aim at transformation rather than simply safely promoting mediocre sex.
6. Foster deep-seated change in the ways clients relate to themselves, others, and sex, rather than just aiming to contain problematic (e.g. non-consensual) sexual behaviours.
7. Offer multiple options to clients. They may choose to just do what works to enable erections, penetration, or orgasms, and we should honour that choice if so, but if we offer other alternatives alongside this they may choose, for example, to deepen their relationship, to transform their thinking about sex, or to address their lives more widely.
8. Aim higher than returning clients to adequate sexual functioning and work with them toward “sex worth wanting” though being vulnerable and authentic, and through tuning into their bodies and their engagement with others.

We agree that it behooves all psychologists engaging with sex research and clinical practice to look deeply into their own assumptions about sex as well as looking critically outwards to the cultural messages around them. Uncritical practices in sex therapy often serve to reproduce and reinforce problematic assumptions about what constitute sex and sexual problems. Critical approaches work to shift the social norms and roles that maintain clients' suffering. Such critical approaches involve tuning in to the unique experiences and meanings of each client, as well as turning out to challenge the dominant discourses that surround them, taking an interdisciplinary approach such that our work can be truly biopsychosocial.

### *Important Points for Academics:*

As with clinicians, academics are well-advised to take note of the discourses and debates surrounding diagnostic categorizations and practices. There are a number of journals, including *Psychology and Sexuality* and *The International Journal of Sexual Health* (formerly the *Journal of Psychology & Human Sexuality*) that focus specifically on sexual issues in the psychological field.

### **Summary**

- The development of sex therapy as a distinct clinical specialization is a relatively recent phenomenon with its roots in the work of Kinsey and Masters & Johnson, and an emphasis on diagnosis and cognitive-behavioural treatment.

## Sex Therapy

- The diagnostic categories for sexual dysfunctions in the DSM relate to desire, arousal and orgasm, as well as to penis-in-vagina penetration.
- Such an approach has been criticized for being universalizing, heteronormative, rigid and goal-focused, as well as for failing to capture diversities of sexual experience and relational aspects of sex, and pathologizing or stigmatizing certain people, groups, and practices, causing unnecessary harm to clients and to wider communities.
- Critical and social constructionist approaches work with the sexual scripts and values that influence clients and emphasise meanings of sexuality within the client's subjective experience.

### Further reading

- Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1982). *Human sexuality*. New York: HarperCollins.
- Leiblum, S. R. (Ed.). (2007). *Principles and practice of sex therapy*. Surrey: Guilford Press.
- Kleinplatz, P. J. (Ed.) (2012). *New directions in sex therapy: Innovations and alternatives*. New York: Routledge.
- Tiefer, L. (1995). *Sex is not a natural act and other essays*. Boulder, Colo.: Westview Press.
- [http://www.ted.com/talks/al\\_vernacchio\\_sex\\_needs\\_a\\_new\\_metaphor\\_here\\_s\\_one.html](http://www.ted.com/talks/al_vernacchio_sex_needs_a_new_metaphor_here_s_one.html).

### References

- Aanstoos, C. (2012). A Phenomenology of Sexual Experiencing. In P. J. Kleinplatz (Ed.), *New Directions in Sex Therapy, 2nd Ed.* (pp. 51-68). New York: Taylor & Francis Group.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.)*. Washington, DC: Author.
- Athanadiasis, L., Papatharitou, S., Salpiggidis, G., Tsimitsiou, Z., Nakopoulou, E., Kirana, P.-S., . . . Hatzichristou, D. (2006). Educating Physicians to Treat Erectile Dysfunction Patients: Development and Evaluation of a Course on Communication and Management Strategies. *Journal of Sexual Medicine, 3*, 47-55.
- Atwood, J. D., & Klucinec, E. (2007). Current State of Sexuality Theory and Therapy. *Journal of Couple and Relationship Therapy, 6*(1), 57-70.
- Balon, R. (2008). The DSM Criteria of Sexual Dysfunction: Need for a Change. *Journal of Sex & Marital Therapy, 34*(3), 186-197.
- Balon, R., Seagraves, R. T., & Clayton, A. (2007). Issues for DSM-V: Sexual Dysfunction, Disorder, or Variation Along Normal Distribution: Toward Rethinking DSM Criteria of Sexual Dysfunctions. *American Journal of Psychiatry, 164*(2), 198-200.
- Bancroft, J. (2006). Sex Therapy. In S. Bloch (Ed.), *An Introduction to the Psychotherapies, 4th Ed.* (pp. 371-395). Oxford: Oxford University Press.
- Barker, M. (2005). This is My Partner, and This is My...Partner's Partner: Constructing a Polyamorous Identity in a Monogamous World. *Journal of Constructivist Psychology, 18*, 75-88.

## Sex Therapy

- Barker, M. (2011). Existential Sex Therapy. *Sexual and Relationship Therapy, 26*(1), 33-47.
- Barker, M. & Iantaffi, A. (forthcoming, 2015). Social models of disability and sex. In H. Spandler, J. Anderson, & B. Sapey, (Eds.) *Distress or Disability?: Madness and the Politics of Disablement*. Bristol: Policy Press.
- Barker, M., & Langdridge, D. (2010). Whatever Happened to Non-monogamies? Critical Reflections on Recent Research and Theory. *Sexualities, 13*(6), 748-772.
- Barlow, D. H. (1986). Causes of Sexual Dysfunction: The Role of Anxiety and Cognitive Interference. *Journal of Consulting and Clinical Psychology, 54*(2), 140-148.
- Basson, R. (2001). Human Sexual Response Cycles. *Journal of Sex & Marital Therapy, 27*, 33-43.
- Berry, M. D. (2013). Historical Revolutions in Sex Therapy: A Critical Examination of Men's Sexual Dysfunctions and Their Treatment. *Journal of Sex & Marital Therapy, 39*(1), 21-39.
- Berry, M. D., & Barker, M. (2013). Extraordinary interventions for extraordinary clients: existential sex therapy and open non-monogamy. *Sexual and Relationship Therapy*(ahead-of-print), 1-10.
- Berry, M. D., & Berry, P. D. (2013). Contemporary Treatment of Sexual Dysfunction: Reexamining the Biopsychosocial Model. *J Sex Med*.
- Denman, C. (2004). *Sexuality: A Biopsychosocial Approach*. New York: Palgrave Macmillan.
- Drescher, J. (2010). Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the *Diagnostic and Statistical Manual*. *Archives of Sexual Behavior, 39*(2), 427-460.
- Fonagy, P. (2008). A Genuinely Developmental theory of sexual enjoyment and its implications for psychoanalytic technique. *Journal of the American Psychoanalytic Association, 56*(11), 11-36.
- Freud, S. (1961). Three Essays on the Theory of Sexuality (J. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 7, pp. 123-243). London: Hogarth press.
- Gathorne-Hardy, J. (1998). *Kinsey: Sex the Measure of All Things*. Bloomington, Ind.: Indiana University Press.
- Giami, A. (2002). Sexual Health: The Emergence, Development, and Diversity of a Concept. *Annual Review of Sex Research, 13*(1), 1-35.
- Giraldi, A., Rellini, A. H., Pfaus, J., & Laan, E. (2013). Female sexual arousal disorders. *Journal of Sexual Medicine, 10*(1), 58-73. doi: 10.1111/j.1743-6109.2012.02820.x
- Goodwach, R. (2005). Sex Therapy: Historical Evolution, Current Practice. Part I. *Australian and New Zealand Journal of Family Therapy, 26*(3), 155-164.
- Grace, V., Potts, A., Gavey, N., & Vares, T. (2006). The Discursive Condition of Viagra. *Sexualities, 9*(3), 295-314.
- Hartmann, U. (2009). Sigmund Freud and His Impact on Our Understanding of Male Sexual Dysfunction. *Journal of Sexual Medicine, 6*(8), 2332-2339.
- Hawton, K. (1985). *Sex Therapy: A Practical Guide*. Northvale, NJ: Aronson.
- Kaplan, H. S. (1974). *The New Sex Therapy*. New York: Brunner/Mazel.
- Kaplan, H. S. (1979). *Disorders of Sexual Desire*. New York: Brunner/Mazel.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual Behavior in the Human Male*. Philadelphia: W.B. Saunders.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1953). *Sexual Behavior in the Human Female*. Philadelphia: Saunders.
- Kleinplatz, P. J. (2012a). Is That all There is? A New Critique of the Goals of Sex Therapy. In P. J. Kleinplatz (Ed.), *New Directions in Sex Therapy: Innovations and Alternatives, 2nd Ed.* (pp. 101-118). New York: Routledge.

## Sex Therapy

- Kleinplatz, P. J. (Ed.). (2012b). *New directions in sex therapy: Innovations and alternatives, 2nd ed.* New York, NY: Routledge.
- Krueger, R. F., & Piasecki, T. M. (2002). Toward a dimensional and psychometrically-informed approach to conceptualizing psychopathology. *Behav Res Ther*, *40*(5), 485-499.
- Leiblum, S., & Wiegel, M. (2002). Psychotherapeutic Interventions for Treating Female Sexual Dysfunction. *World Journal of Urology*, *20*(2), 127-136.
- Levine, S. B., Hasan, S., & Boraz, M. (2009). Male Hypoactive Sexual Desire Disorder. In L. R. DeRogatis & R. T. Segraves (Eds.), *Clinical Manual of Sexual Disorders* (pp. 160-184). Washington, DC: American Psychiatric Association.
- Levine, S. B., Risen, C. B., & Althof, S. (Eds.). (2010). *Handbook of Clinical Sexuality for Mental Health Professionals, 2nd Ed.* New York, NY: Routledge.
- Masters, W. H., & Johnson, V. E. (1966). *Human Sexual Response*. Boston: Little, Brown.
- Masters, W. H., & Johnson, V. E. (1970). *Human Sexual Inadequacy*. Boston: Little, Brown.
- McCabe, M., Althof, S. E., Assalian, P., Chevret-Measson, M., Leiblum, S. R., Simonelli, C., & Wylie, K. (2010). Psychological and interpersonal dimensions of sexual function and dysfunction. *J Sex Med*, *7*(1 Pt 2), 327-336.
- McCarthy, B., & McDonald, D. (2009). Assessment, treatment, and relapse prevention: male hypoactive sexual desire disorder. [Review]. *Journal of Sex & Marital Therapy*, *35*(1), 58-67. doi: 10.1080/00926230802525653
- McCarthy, B. W., & McDonald, D. O. (2009). Psychobiosocial Versus Biomedical Models of Treatment: Semantics or Substance. *Sexual and Relationship Therapy*, *24*(1), 30-37.
- McCarthy, T. (1981). Freud and the Problem of Sexuality. *Journal of the History of the Behavioural Sciences*, *17*, 332-339.
- McLaren, A. (2007). *Impotence: A Cultural History*. Chicago and London: The University of Chicago Press.
- Meana, M., & Jones, S. (2011). Developments and trends in sex therapy. *Advances in Psychosomatic Medicine*, *31*, 57-71.
- Metz, M., & McCarthy, B. W. (2007). The 'Good-Enough Sex' Model for Couple Sexual Satisfaction. *Sexual and Relationship Therapy*, *22*(3), 351-362.
- Mitchell, K., & Graham, C. A. (2008). Two Challenges for the Classification of Sexual Dysfunction. *The Journal of Sexual Medicine*, *5*(7), 1552-1558.
- Montorsi, F., Basson, R., Adaikan, P. G., Becher, E., Clayton, A., Giuliano, F., . . . Sharlip, I. (Eds.). (2010). *Sexual Medicine: Sexual Dysfunction in Men and Woman, 3rd International Consultation on Sexual and Erectile Dysfunction co-sponsored by the World Health Organization (WHO), International Society of Sexual and Impotence Research (ISIR) and Societe Internationale D'Urologie (SIU)*. Paris: Health Publications Ltd.
- Nichols, M., & Shernoff, M. (2007). Therapy With Sexual Minorities: Queering Practice. In S. Leiblum (Ed.), *Principles and Practices of Sex Therapy* (4th ed., pp. 379-415). New York: The Guilford Press.
- Organization, P. A. H. O. W. H. (2000). *Promotion of Sexual Health: Recommendations for Action*. Paper presented at the Proceedings of a regional consultation convened by Pan American Health Organization (PAHO), World Health Organization (WHO) (In collaboration with the World Association for Sexology. Retrieved from <http://www.2.rz.hu-berlin.de/sexology>.
- Perelman, M. A. (2005). Integrating Sex Therapy and Pharmacotherapy. In R. Balon & R. Segraves (Eds.), *Handbook of Sexual Dysfunction* (pp. 13-41). New York: Taylor and Francis.

## Sex Therapy

- Richards, C., & Barker, M. (2013). *Sexuality and Gender for Mental Health Professionals: A Practical Guide*. London: Sage Publications.
- Risen, C. B. (2010). Listening to Sexual Stories. In S. B. Levine, C. B. Risen & S. Althof (Eds.), *Handbook of Clinical Sexuality for Mental Health Professionals* (pp. 3-20). New York: Routledge.
- Robinson, P. (1976). *The Modernization of Sex*. London: Harper & Row.
- Schilt, K. (2009). 'Gender Normals,' Transgender People, and the Social Maintenance of Heterosexuality. *Gender and Society, 23*(4), 440-464.
- Semans, J. H. (1956). Premature Ejaculation: A New Approach. *Southern Medical Journal, 49*, 353-358.
- Stevenson, R., & Elliott, S. (2009). Sexual Disorders With Comorbid Psychiatric or Physical Illness. In R. Balon & R. T. Segraves (Eds.), *Clinical Manual of Sexual Disorders* (pp. 59-90). Washington: American Psychiatric Publishing, Inc.
- Temple-Smith, M., Hammond, J., Pyett, P., & Presswell, N. (1996). Barriers to Sexual History Taking in General Practice. *Aust Fam Physician, 25*, S71-74.
- Tiefer, L. (1991). Historical, Scientific, Clinical and Feminist Criticisms of 'The Human Sex Response Cycle'. *Annual Review of Sexual Research, 2*, 1-23.
- Tiefer, L. (2006). Sex Therapy as a Humanistic Enterprise. *Sexual and Relationship Therapy, 21*(3), 359-375.
- Tiefer, L. (2010a). Beyond the Medical Model of Women's Sexual Problems: A Campaign to Resist the Promotion of 'Female Sexual Dysfunction'. *Sexual and Relationship Therapy, 25*(2), 197-205.
- Tiefer, L. (2010b). Still Resisting After all These Years: An Update on Sexuo-medicalization and on the New View Campaign to Challenge the Medicalization of Women's Sexuality. *Sexual and Relationship Therapy, 25*(2), 189-196.
- Toates, F. (2009). An integrative theoretical framework for understanding sexual motivation, arousal, and behavior. *J Sex Res, 46*(2-3), 168-193.
- Tsimitsiou, Z., Hatzimouratidis, K., Nakopoulou, E., Kyrana, E., Salpigidis, G., & Hatzichristou, D. (2006). Predictors of Physicians' Involvement in Addressing Sexual Health Issues. *Journal of Sexual Medicine, 3*(4), 583-588.
- Weeks, G. R. (2005). The Emergence of a New Paradigm in Sex Therapy: Integration. *Sexual and Relationship Therapy, 20*(1), 89-103.
- Widiger, T. A., & Samuel, D. B. (2005). Diagnostic Categories or Dimensions? A Question for the Diagnostic and Statistical Manual of Mental Disorders--Fifth Edition. *Journal of Abnormal Psychology, 114*(4), 494-504.
- Wincze, J. P., & Carey, M. P. (2001). *Sexual Dysfunction: A Guide for Assessment and Treatment* (2nd ed.). New York: The Guilford Press.
- World Health Organization. (1993). *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: World Health Organization.